

Letters to the Editor

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Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to karl.miller@erlanger.org or to my attention at *Family Medicine* Letters to the Editor Section, University of Tennessee, Chattanooga Unit, Department of Family Medicine, 1100 East Third Street, Chattanooga, TN 37402. 423-778-2957. Fax: 423-778-2959. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

Ethics and Spirituality Are Not Synonyms

To the Editor:

The survey by King and Crisp¹ raised an implicit finding that apparently was outside the scope of the paper. Respondents may not know what spirituality is, much less how it should be taught. Why else would the most frequently used formal spirituality content be a document about ethics that does not even mention spirituality, the AAFP Core Educational Guidelines on Medical Ethics²?

Ethics and spirituality are deeply connected, but they are not the same.

The Bioethics Council of New Zealand, Toi Te Taiao,³ offers some simple definitions of ethics and spirituality:

Ethics are moral principles that govern or influence behaviour and the choices we make as individuals and communities.

Spirituality is a term commonly used to describe how people relate themselves to other generations, the natural and created environment, the universe, other's beliefs, and to their idea of an agent/agency of significance (eg, God).

In other words, ethics are constructs that guide, direct, and manifest our spiritual development and actions.

Before you can develop and disseminate curricula and tools, you need to understand what it is that you are teaching—and why. Defining terms seems to be a good place to start.

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Becoming a Research-oriented Family Physician

To the Editor:

Mindy Smith, MD, MS, performed interesting research on the impact of research curricula on post-residency practice.¹ She justly concludes that the creation of curricula in which graduates are stimulated to practice evidence-based medicine and participate in research is necessary.

About a year ago, I (ToH) wrote an article in the journal of the Dutch College of General Practitioners in which I asked vocational trainers to stimulate research and research training in the vocational training program of family medicine residents.² In my own vocational training group, I noticed a very low level of interest in research among family medicine residents. How is this possible? Isn't each resident a consumer of research? In my opinion, training and participation in research stimulate critical appraisal of the literature and improve the quality of patient care based on evidence-based methods.

As a result of the Kingston conference, Van Weel and Rosser emphasize the importance of high-quality, evidence-based family medicine in improving health care globally.³ This is only possible when family physicians participate in and contribute to research. The most relevant research questions and problems are derived from family physicians' practices.

In The Netherlands, there is an ongoing effort to train residents who are interested in research. These "research-interested" residents follow a special training program in which they combine their vocational training with a research project in primary care. As a result, the length of the vocational training is extended, and these residents not

only become family physicians but also write a PhD thesis on a research topic in family medicine.

At the moment, there are approximately 35 family medicine residents in The Netherlands following this program. We think these residents will generate a lot of new and relevant research in the future because of their experience in both family medicine and research. In this way, family medicine in The Netherlands prepares clinical scientists for a practice-oriented research career. We notice the advantages of this combined training program every day in daily practice. Moreover, it is a challenging way of becoming a research-oriented family physician. Maybe this could be part of the missing link in creating “research-savvy” graduates who practice evidence-based medicine and participate in research.

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Author's Reply:

In reply to the letter by olde Hartman and colleagues, I applaud the efforts in The Netherlands to train residents who are interested in research by creating a special training program that includes a research project in primary care. I would be interested in following the paths of these 35 residents following graduation to see whether this training

has the desired effects of increasing research capacity. We have similar training at the postgraduate level through fellowship programs, but I am afraid that these types of programs reach only a small minority of our residents—those who have a passion for research.

I would like to see us reach all of our residents with an enhanced curriculum that guides them toward evidence-based practice through using evidence at the point of care and gives them the skill and interest to pursue their clinical questions. Perhaps through residency program participation in systematic data gathering through practice audits, local quality improvement projects, or even state and national research networks, residents might broaden their ideas about research to include everyday practice. Then we might truly see a large cadre of graduates who practice evidence-based medicine and participate in research.

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Continuity of Care

To the Editor:

“When I use a word,” Humpty Dumpty said in rather a scornful tone, “it means just what I choose it to mean—neither more nor less.”

“The question is,” said Alice, “whether you CAN make words mean so many different things.”¹

The concept of continuity of care is elusive, and investigation has been hampered by the difficulty of establishing a clear, agreed-on definition. Some models of continuity of care are rather broad, as exemplified by the American Academy of Family Physicians definition, while other authors have proposed simple numerical indices measuring the proportion of consultations with a named physician. Multidimensional models of continuity of care^{2,3} recognize two core concepts: continuity as a “continuous caring relationship”

(relational or interpersonal continuity) and continuity as a “seamless service” (management continuity or team and cross-boundary continuity). These may be supported by continuity of information.

In their recent empirical study, Nair and colleagues⁴ held focus groups with diabetic patients to explore their experiences of continuity of care. They argued that a researcher-focused definition of continuity of care may miss aspects of continuity that are important to patients. They therefore asked patients to discuss concepts of continuity of care but “few parameters were placed on participants’ discussion” (page 119). The resulting data were used to develop a classification of five factors that enhance or detract from continuity of care, including access to services, interactions with physician, interactions with other health care providers, personal self-responsibility, and communication. These were used to inform the development of a questionnaire measure. However, we question whether the concept of continuity of care can be used to mean so many different things. In particular, we question how self-care or personal self-responsibility can be justified as representing an aspect of continuity of care according to existing models.

Like Nair et al, we have recently been investigating the values and experiences of diabetic patients with respect to continuity of care, but we used a different approach. Unlike Nair et al, we did not ask patients to discuss “continuity of care” because we believed that patients would not be familiar with the meaning of the concept in the context of health care. Instead we referred to a conceptual model of continuity of care that encompassed the six elements of continuity described by Freeman et al.² For example, without mention of continuity, we discussed patients’ views concerning the value of seeing a regular professional, factors that